

**HOUSE OF DELEGATES**  
**ACTION OF BOARD REPORTS**

**ACTION REPORT #1 – HOD Resolution 5-06A – Dues for Osteopathic Physicians.**

**The House approved the Board’s recommendation that his resolution be DISAPPROVED.**

RECOMMENDATION: That the 2007 House of Delegates disapprove Resolution 5-06A, “Dues for Osteopathic Physicians.”

Resolution 5-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on Membership Recruitment and Retention for review and recommendation.

Resolution 5-06A asked that osteopathic physicians who belong to the American Medical Association be allowed to maintain membership in MSMS and its component societies at a reduced rate.

The Committee considered this resolution at its meeting on September 12, 2006.

Currently, 585 osteopathic physicians in Michigan belong to the AMA, 186 of whom belong to MSMS. While the resolution did not specify the amount of the discount, subsequent discussions with the author indicated the intent was a substantial one.

By implementing such a policy, no matter the discount, there would be an automatic loss in dues revenue:

Current dues revenue received from DO members  
186 x \$495 = \$92,070

Potential loss of dues revenue  
\$50 Discount = \$82,770 (-\$9,300)  
\$100 Discount = \$73,470 (-\$18,600)  
\$150 Discount = \$64,170 (-\$27,900)

Additionally, the Committee believed that the potential to offset this loss with the addition of new members from the other 399 DO physicians who belong only to the AMA is unlikely.

Another consideration in the Committee's recommendation is the long-standing "Gentleman's Agreement" between MSMS and the Michigan Osteopathic Association to not directly recruit osteopathic physicians. Providing a discount to the 399 who are members of the AMA, but not MSMS (and may not belong to MOA) is a violation of this agreement. Additionally, since resolutions asking for discounted osteopathic membership seem to be presented almost annually at the House of Delegates, the Committee members requested that this "Gentleman's Agreement" be made aware to both the MSMS Board of Directors and MSMS staff who oversee the HOD reference committees, so that the policy does not have to be legislated each year.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates disapprove this resolution.

*RATIONALE: The Committee agreed that the potential loss of revenue is significant and therefore the compelling reason to adopt the Board's recommendation to disapprove the resolution.*

## **BOARD ACTION REPORT #2 – HOD Resolution 13-06A – MSMS to Provide Member-Only Benefits.**

**The House approved the Board's recommendation that this resolution be DISAPPROVED.**

RECOMMENDATION: That the 2007 House of Delegates disapprove Resolution 13-06A, "MSMS to Provide Member-Only Benefits."

Resolution 13-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on Membership Recruitment and Retention for review and recommendation.

Resolution 13-06A asked that MSMS seek to provide a number of member-only benefits to encourage membership in the society, such as free CME during the MSMS Annual Scientific Meeting and during county society approved meetings to members only.

The Committee considered this resolution at its meeting on December 12, 2006.

While there is a charge for MSMS CME programs, the member fee is substantially lower than what non-members are charged. CME fees bring in approximately \$90,000 revenue annually, which is approximately one-fifth the MSMS Foundation revenue budget for 2007. This revenue allows the registration fees to stay low.

Additionally, a new member benefit was introduced this year, implemented in part because of this resolution. Members who paid their 2007 membership dues by December 31, 2006, will receive a voucher for one free CME course during 2007 (excludes ASM).

The Committee also considered the vast array of free member-only benefits provided including services of the Reimbursement Advocate, coding assistance, legal checklists, legal alerts, member-only discounts for American Physician liability insurance, and up to 86 percent tax deductibility of dues. Committee members asked that MSMS create more awareness of these and other free member benefits in its communication vehicles.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates disapprove this resolution.

**BOARD ACTION REPORT #3 – HOD Resolution 15-06A – MSMS to Develop “Expert Plaintiffs Witness Testimony Review Service.”**

**The House approved the Board’s recommendation that this resolution be ADOPTED AS AMENDED.**

RECOMMENDATION: That the 2007 House of Delegates adopt Resolution 15-06A, “Expert Witness Testimony Review Service,” as amended to read:

RESOLVED: That MSMS pursue policies that permit the use of peer review of expert witness testimony with the expectation that deliberately false, fraudulent, or deceptive testimony be appropriately sanctioned by MSMS, the respective specialty society, and the Board of Medicine.

Resolution 15-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on State Legislation and Regulations for review and recommendation.

Resolution 15-06A asked that MSMS establish at least a member’s only service to somehow sanction these physicians.

The Committee on State Legislation and Regulations is aware that there is considerable frustration on the part of physicians who repeatedly see medical experts who provide testimony based upon questionable science. Furthermore, the Committee believes that organized medicine does have a role to play in providing guidance as to how best address physicians who continue to provide testimony that is outside of the established standards.

This was amended to reflect the need for a more comprehensive approach in order to address the scope of this problem. The wording of the resolved reflects the intent of seeking policies that would create a mechanism to appropriately sanction physicians who provide false or misleading testimony. Legislation would be needed to include expert testimony under the jurisdiction of the Board of Medicine. Likewise, additional legislative and regulatory consideration may be needed to assure that state medical

societies and specialty societies may serve in a capacity of providing peer review relative to expert testimony.

The Committee discussed some of the high profile cases that have led to the court decisions that have provided the framework to allow a peer review function for expert testimony. The Committee was supportive of the efforts to identify questionable testimony but did not believe that limiting this role to MSMS was sufficient and agree with the intent of the recommendation. The Committee concluded that in an effort to create as comprehensive of a solution as possible, county medical societies should be added to list of groups to serve this function.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates adopt this resolution as amended.

*RATIONALE: The Committee did not hear any testimony on this Board Action Report and were supportive of the review by the Board on this issue.*

**BOARD ACTION REPORT #4 - HOD Resolution 16-06A– Expand Good Samaritan Acts and HOD Resolution 30-06A – Good Samaritan Coverage for Project Access Physicians.**

**The House adopted the Board’s recommendation that this resolution be APPROVED.**

RECOMMENDATION: That the 2007 House of Delegates approve Resolution 16-06A, “Expand Good Samaritan Acts.”

Resolutions 16-06A and 30-06A were considered together and the substitute resolution was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on State Legislation and Regulations for review and recommendation.

Currently, the law limits liability immunity to care provided in free clinics. As programs to offer free care expand, it was found that the limits of the current law place delivery of certain types of charitable care at risk of exposure to liability.

The Committee received an update regarding the status of the current laws related to liability immunity for physicians providing free care. Additionally, the Committee was provided with the specific program in Kent County that is not covered under the existing law. The Committee is supportive of expanding the “Good Samaritan Act” to the greatest extent possible to provide liability immunity for free care delivered in physician offices.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates approve this resolution.

*RATIONALE: The Committee heard testimony asking that the resolved portion of the resolution seek liability immunity for uncompensated care provided in a physician office as well as other venues. Originally, the resolution was limited to only the physician office. The original author of the resolution considered this a friendly amendment. Otherwise, the Committee was overwhelmingly supportive of expanding the Good Samaritan Act to apply to situations when physicians are providing uncompensated care.*

## **BOARD ACTION REPORT #5 – HOD Resolution 28-06A – Emergency Room Specialty Coverage.**

**The House approved the Board’s recommendation that this resolution be ADOPTED AS AMENDED.**

RECOMMENDATION: That the 2007 House of Delegates adopt Resolution 28-06A, “Emergency Room Specialty Coverage,” as amended to read:

RESOLVED: That MSMS collaborate with the Michigan Hospital Association and other appropriate organizations to further explore the problem of emergency call coverage and to evaluate the feasibility of a policy to compensate physicians appropriately to cover the costs of providing emergency coverage safely; and be it further

RESOLVED: That MSMS ask the Michigan Congressional delegation to support HR 882, the Access to Emergency Medical Services Act of 2007.

Resolution 28-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on Health Care Quality, Efficiency and Economics for review and recommendation.

Resolution 28-06A originally asked that the Michigan Delegation to the AMA ask the AMA to develop a program that would recommend proper compensation for covering physicians.

The author of the resolution informed the Committee that physicians are leaving busier hospitals to avoid more frequent call, and that sometimes call physicians are advising hospital employed PAs under the guise of arranging follow up care even when they cannot confirm that an emergency physician has seen the patient. Based on supply and demand issues, some specialties may have arrangements with the hospital to be compensated for call. For private practice physicians that have to take a disproportionate amount of call, it makes it difficult to keep their regular office hours if the burden of call in a given time period is too great

The burden of emergency call coverage is not just a Michigan issue, and it is driven by a variety of reasons: EMTALA requirements, the uncompensated care burden, liability issues, decreased reimbursement from Medicare and Medicaid, difficulties obtaining payment from managed care entities, lifestyle issues, and the regionalization of medical practice. All of these factors create disincentives for physicians to participate in emergency call coverage, and there is national recognition that physicians have reduced their hospital privileges to reduce their exposure to emergency department patients and on-call duties.

The Committee agreed that getting information from the Michigan Health and Hospital Association about how hospitals are constructing reimbursement arrangements with various specialties and verifying hospital medical staff and payer responsibility for emergency specialist coverage would be important to developing long term solutions to this problem. The Committee also discussed the Access to Emergency Medical Services Act, which addresses a variety of issues that threaten access to emergency care, including the availability of on-call specialists and medical liability issues. This bill was reintroduced as HR 882 in February 2007.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates adopt this resolution as amended.

#### **BOARD ACTION REPORT #6 – HOD Resolution 32-06A – Translator Services.**

**The House approved the Board’s recommendation that this resolution be ADOPTED.**

RECOMMENDATION: That the 2007 House of Delegates adopt Resolution 32-06A, “Translator Services.”

Resolution 32-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on State Legislation and Regulations for review and recommendation.

Resolution 32-06A asked that MSMS work with the appropriate entities to ensure that a patient requiring the translator service who fails to show up for his/her appointment may be billed and held accountable for the cost of the translator service unless he/she cancels his/her appointment well ahead of time where the translator service can be cancelled and not incur a cost to the doctor.

The Committee was aware of many examples where a translator was required and that the cost for the service was considerably more than the reimbursement for the physician service provided. The Committee was informed by MSMS Legal Counsel that implementation of this resolution may be limited because federal rules and laws such as the Americans with Disabilities Act would likely trump state efforts to address this issue.

The discussion also turned to issues of risk management with respect to the use of translator services. The law requires that a reasonable accommodation be made when treating the patient. Some physicians consider using a family member as an option; however, the Committee envisioned circumstances whereby a family member is not able to adequately translate medical terms or symptoms of the patient, which could later be the basis of a liability suit.

In any case, the Committee agreed that this resolution may provide some limited degree of relief for physicians regarding this issue. Furthermore, it was very clear that information in addition to the existing MSMS Legal Brief compiled by MSMS staff and Legal Counsel would be of great value to practicing physicians in this regard.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates adopt this resolution.

### **BOARD ACTION REPORT #7 – HOD Resolution 38-06A – Peer Review Process.**

**The House approved the Board's recommendation that NO ACTION be taken on this resolution.**

RECOMMENDATION: That 2007 House of Delegates take no action on Resolution 38-06A, "Peer Review Process."

Resolution 38-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Task Force on Federation Issues.

Resolution 38-06A asked that MSMS amend its bylaws as needed to take over from county medical societies the peer review functions of its members; and that county medical societies serve in an advisory capacity to offer assistance as needed throughout the MSMS peer review process.

The Task Force met on November 8, 2006, and discussed the resolution in-depth and unanimously agreed that one of the basic functions of a county medical society is to conduct peer review at the local level in an effort to resolve physician/patient issues without formal proceedings or reporting the case to state government. Members pointed out that most complaints by patients against local physicians are "fairly simple" and best determined at the local level.

There is a mechanism that currently exists by which a county may refer a more complex county peer review issue to the MSMS Judicial Commission.

After considerable discussion, the Task Force recommended that no action be taken on this resolution and instead that a letter be sent to the resolution author and to all other county medical society officers statewide outlining assistance county societies can get from MSMS regarding peer review problems.

The MSMS Board of Directors approved the recommendation of the Task Force and recommends that the 2007 House of Delegates take no action on this resolution.

*RATIONALE: Because there is a current mechanism for which a county may refer a complex county peer review issue to the MSMS Judicial Commission, the Committee agreed with the Board's recommendation to take no action.*

#### **BOARD ACTION REPORT #8 – HOD Resolution 44-06A – Junk Food Tax.**

**The House approved the Board's recommendation that this resolution NOT BE ADOPTED.**

RECOMMENDATION: That the 2007 House of Delegates not adopt Resolution 44-06A, "Junk Food Tax."

Resolution 44-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Liaison Committee with Michigan's Public Health for review and recommendation.

Resolution 44-06A asked that MSMS seek legislation that would place a 25 percent tax on the net income from junk food sold in school vending machines and that no more than 25 percent of the food offered in school vending machines may be classified as junk food. The House of Delegates Reference Committee on Public Health supported eliminating junk food in schools; however, they were uncomfortable with a junk food tax.

While the Committee encourages state government, legislators, and stakeholders to discuss and enact legislation that would encourage healthy nutrition, Committee members were not supportive of this proposed regulatory policy (including a tax) as it was too narrow in its scope and potential impact on healthy eating in schools and that is likely to be redundant in relation to similar, but more expansive, policy initiatives under discussion.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates not adopt this resolution.

#### **BOARD ACTION REPORT #9 – HOD Resolution 50-06A – Medication Availability.**

**The House approved the Board's recommendation that NO ACTION be taken on this resolution.**

RECOMMENDATION: That the 2007 House of Delegates take no action on Resolution 50-06A, "Medication Availability."

Resolution 50-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Liaison Committee with Michigan's Public Health for review and recommendation.

Resolution 50-06A asked that MSMS work with the Michigan Pharmacists Association to create a requirement that all pharmacies maintain a certain formulary on hand at all times to assure access to these medications by patients.

MSMS staff contacted the Michigan Pharmacists' Association (MPA) to determine what policies may already exist in this regard.

MSMS was informed that pharmacists are not obligated to stock specific drugs or any specific quantity of drugs. As a practical matter, most community pharmacies purchase drugs based on their experience as well as the needs of their communities. The staff at MPA was not aware of and could not envision a circumstance where a pharmacy would not stock commonly prescribed drugs. Furthermore, it was explained that lapses in supplies of drugs may be due to the wholesaler or supplier. In those instances, pharmacists may contact other pharmacies to borrow or purchase the necessary quantity for the customer.

The Committee believed that the variety of drugs stocked by a pharmacy is primarily a business decision. Furthermore, it was the sense of the Committee that the existing framework has been demonstrated to work fairly well and is not in need of change.

The Committee was not aware of a compelling reason or need to support efforts to create a minimum formulary and that all 24-hour pharmacies carry the aforementioned formulary.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates take no action on this resolution.

### **BOARD ACTION REPORT #10 – HOD Resolution 53-06A – Reporting Stolen Drug Enforcement Agency Numbers.**

**The House approved the Board's recommendation that this resolution be ADOPTED.**

RECOMMENDATION ONE: That the 2007 House of Delegates adopt Resolution 53-06A, "Reporting Stolen Drug Enforcement Agency Numbers."

RECOMMENDATION TWO: That MSMS look into the reporting system of narcotic prescriptions and request that the state of Michigan notify physicians and pharmacists of any change to the electronic tracking system.

Resolution 53-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Liaison Committee with Michigan's Public Health for review and recommendation.

Resolution 53-06A asked that MSMS work with the Michigan Pharmacists Association and the state of Michigan to create a process to alert physicians and pharmacists of stolen Drug Enforcement Agency (DEA) numbers.

The Michigan Pharmacists Association shared concerns regarding the use of stolen DEA numbers to obtain prescriptions illegally. While some communities have decentralized ways of informing community pharmacies and physician offices when numbers are stolen; a statewide initiative would streamline this process and be a benefit to physicians and pharmacists seeking to limit illegal use of stolen DEA numbers.

Additionally, the Committee was made aware that the system is scheduled to be down for the entire month of March for upgrades. Committee members were concerned with changes made to the electronic tracking system without prior notification to physicians and pharmacists.

The MSMS Board of Directors agreed with the recommendation of the Committee and recommends that the 2007 House of Delegates adopt this resolution as amended with the addition of the second recommendation.

**BOARD ACTION REPORT #11 – HOD Resolution 59-06A – MSMS Work with Michigan Secretary of State Office to Disseminate Medical Durable Power of Attorney.**

**The House approved the Board's recommendation that his resolution be ADOPTED.**

RECOMMENDATION: That the 2007 House of Delegates adopt Resolution 59-06A, "Work with Michigan Secretary of State to Disseminate Medical Durable Power of Attorney."

Resolution 59-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Liaison Committee with Michigan's Public Health for review and recommendation.

Resolution 59-06A asked MSMS to work with the Michigan Secretary of State office to disseminate medical durable power of attorney information and intent in a fashion similar to that carried out for organ donations.

The Committee is well aware of the need for greater use of medical durable power of attorney documents by the public. This need has been reinforced by some very high

profile cases that have been deliberated in the media as well as state and national politics.

Currently, the Secretary of State provides literature regarding organ donations to all licensed drivers at the time of licensure renewal, as well as making pamphlets available for anyone entering a Secretary of State branch office. The Committee was very supportive of this effort and acknowledges the importance of the need for patients to obtain and complete one of these documents.

The MSMS Board of Directors approved the recommendation of the Committee and recommends to the 2007 House of Delegates that this resolution be adopted.

### **BOARD ACTION REPORT #12 – HOD Resolution 67-06A – Impaired Drivers.**

**The House approved the Board’s recommendation that this resolution be ADOPTED AS AMENDED.**

RECOMMENDATION: That the 2007 House of Delegates adopt Resolution 67-06A, “Impaired Drivers,” as amended to read:

RESOLVED: That MSMS urge the Governor and legislature of the state of Michigan to absolve physicians from the requirement of confidentiality when reporting impaired drivers.

Resolution 67-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Liaison Committee with Michigan’s Public Health for review and recommendation.

This Resolution originally asked that MSMS urge Governor Granholm and the Michigan legislature to support a policy that would mandate the reporting of impaired drivers who persistently ignore the advice of a licensed physician not to drive, similar to the mandatory report of certain contagious diseases; and that MSMS urge the Governor and legislature of the state of Michigan to indemnify physicians from the requirement of confidentiality when reporting impaired drivers who persistently ignore the advice of a licensed physician not to drive, similar to the mandatory report of certain contagious diseases.

The Committee has historically been opposed to any mandatory reporting due to the threat it poses to the physician/patient relationship. Patients concerned that a physician may have to report their condition to the Secretary of State may withhold important health information or simply avoid going to the doctor. Additionally, there was concern expressed that making reporting mandatory could put physicians at risk if they were to fail to report a driver who later gets into an accident due to an impairment.

After a lengthy discussion, the Board agreed to make a friendly amendment to change the term “indemnify” to “absolve” in order to have a more appropriate legal term in the resolution; and to eliminate the first resolved.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates adopt this resolution as amended.

### **BOARD ACTION REPORT #13 – HOD Resolution 77-06A – Best Practices for Pharmaceutical Industry Interactions.**

**The House approved the Board’s recommendation that NO ACTION be taken on this resolution.**

RECOMMENDATION ONE: That the 2007 House of Delegates take no action on Resolution 77-06A, “Best Practices for Pharmaceutical industry Interactions.”

RECOMMENDATION TWO: That the MSMS Board of Directors ask the Committee on Bioethics to review the proposed regulations on physician ties to pharmaceutical companies outlined in a recent issue of JAMA and advise the Board as to their appropriateness for MSMS.

Resolution 77-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Liaison Committee with Michigan’s Public Health for review and recommendation.

Resolution 77-06A asked that MSMS adopt the following “best practices for pharmaceutical industry interactions:”

- (1) do not bring a non-health care professional guest to a pharmaceutical company sponsored event;
- (2) if samples are accepted, provide a witness signature for those representatives who request it (or simply don’t accept samples); and
- (3) if a meal is scheduled with the office, show up or if unable to attend, ask staff to cancel it.

The Board agreed with the Committee that MSMS should take no action on this resolution since the Board has already approved a comprehensive policy that “encourages physicians to critical critically examine relationships with the pharmaceutical industry to assess benefit versus harm for the individual patient.” The Committee recognizes the need for a policy that would address many of the specific concerns cited in this resolution and those identified in a recent issue of JAMA.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates take no action on the original resolution and adopt Recommendation Two in lieu of the resolution.

## **BOARD ACTION REPORT #14 – HOD Resolution 68-06A – Single-Payer Health Insurance.**

### **The House ADOPTED THIS RESOLUTION AS AMENDED.**

The amended resolved reads:

RESOLVED: That MSMS support the ongoing investigation, discussion and physician education of a single-payer health insurance program, the AMA plan for expanding coverage for the uninsured and increasing access to care, the Michigan First proposal, county indigent plans, and other innovative systems of payment in Michigan and the United States.

RECOMMENDATION: That the 2007 House of Delegates adopt this report in lieu of Resolution 68-06A, “Single-Payer Health Insurance.”

Resolution 68-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on Health Care Quality, Efficiency and Economics for review and recommendation.

Resolution 68-06A asked that MSMS support the adoption of a single-payer health insurance program in the United States and that it explore opportunities to partner with other like-minded organizations that favor the single-payer approach to providing health insurance to all Americans.

The Committee had an extensive and earnest discussion of the resolution, noting that the position in the *Future of Medicine* plan supporting universal coverage was an important milestone in MSMS policy. The resolution author participated in the discussion. He stated that the distinction needed to be made between socialized medicine, when the government owns the hospitals and employs the physicians as civil servants, and a single payer system, which could maintain the private delivery system but pay for it with public funds through a central mechanism.

Committee members raised many concerns about moving from a position endorsing universal coverage to one supporting a single payer system, including the need to address incentives and disincentives for administrative and clinical efficiency, the burden of compliance and liability, and determination of the ‘right’ amount of administrative expense, among other issues. The Committee recognized that the work of the Essential Benefits Work Group, which includes many different stakeholders, is the first step toward identifying how the goal of universal coverage could be achieved. Although the Committee did not believe it was an appropriate time for MSMS to take a position supporting a single payer system, the group believed that it was appropriate to continue to debate the pros and cons, learn more about the options and variations (such as the California public-private single payer hybrid proposal), and broaden the discussion within the membership. The Committee suggested that a structured

educational forum with knowledgeable presentations of the pros, cons, and many variations of single payer systems would be an appropriate way to continue the discussion. The conclusions and insights that arise from the educational forum could be presented at the HOD to further educate MSMS members about this important and complex issue.

Given the points raised during the discussion, the Committee voted to support the following action on the issue of single payer:

The Resolution author was in agreement with the decision of the Committee.

That MSMS support the ongoing investigation, discussion and physician education of a single-payer health insurance program and other innovative systems of payment in the United States.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates adopt this report in lieu of the resolution.

*RATIONALE: The amended language addresses the issues raised in Resolution 14-07A, 43-07A, and 53-07A, in addition to addressing the original resolution referred by the 2006 House of Delegates.*

## **BOARD ACTION REPORT #15 – HOD Resolution 82-06A – Pets and Human Food Handling.**

**The House approved the Board’s recommendation that this resolution NOT BE ADOPTED.**

RECOMMENDATION: That the 2007 MSMS House of Delegates not adopt Resolution 82-06A, “Pets and Human Food Handling.”

Resolution 82-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Liaison Committee with Michigan’s Public Health for review and recommendation.

Resolution 82-06A asked that MSMS work with the Departments of Community Health and Agriculture to establish regulations prohibiting the sale of pets in any location that is in close proximity to fresh food sold for human consumption.

The Liaison Committee with Michigan’s Public Health deliberated at length on Resolution 82-06A, “Pets and Human Food Handling.”

Since there are a number of retail stores selling both fresh foods and pets, the author is concerned with the potential transmission of communicable diseases from animals to

humans. The House of Delegates Public Health Committee heard favorable testimony on this resolution, but determined that it lacked the scientific evidence needed to deliver an educated recommendation. The House of Delegates concurred with the recommendation of the Committee and referred it to the MSMS Board of Directors.

The Liaison Committee with Michigan's Public Health confirmed that the state does not have any current laws that prohibit the sale of pets and food in the same retail setting. The Michigan Department of Agriculture (MDA) assured the Committee that local health departments look for cross contamination issues during annual health inspections and address them as they arise. Additionally, MDA and local health departments provide annual food safety training for such establishments.

The Committee concluded that the current law addresses the intent of the resolution and that there is not a high incidence of contamination for these retail settings.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates not adopt this resolution.

#### **BOARD ACTION REPORT #16 - HOD Resolution 9-05A – Geographic Selection of AMA Delegates by MSMS House of Delegates Members.**

**The House approved the Board's recommendation that NO ACTION be taken on the original resolution.**

RECOMMENDATION: That the 2007 MSMS House of Delegates adopt Board Action Report #2 on Resolution 9-05A, "Geographic Selection of AMA Delegates by MSMS House of Delegates Members," which recommends that no action be taken on the original resolution.

Resolution 9-05A was referred to the MSMS Board for study by the 2005 House of Delegates. It came back to the 2006 House of Delegates as Board Action Report #2 with a recommendation from the Board for no action. After considerable discussion on the floor at the 2006 House of Delegates, the House subsequently referred the report and original resolution back to the MSMS Board of Directors once more for additional study.

The Task Force on Federation Issues discussed the resolution at length at its meetings on December 8, 2006, and again on January 31, 2007.

Resolution proponent Carl Hammerstrom, MD, from Marquette, was invited to speak at the December 8 meeting to explain the concept of dividing the state into districts from which delegates and alternate delegates could be elected to the Michigan Delegation to the AMA. He argued that potential candidates from more remote areas do not get the exposure to other members of the MSMS House of Delegates as do those living in the southern half of the Lower Peninsula and, therefore, do not have an equal chance of getting elected to the AMA delegation. He argued that it is costly and difficult for a

member to run an effective campaign statewide and that the streamlined House of Delegates meeting allows little time for a candidate to become known. Doctor Hammerstrom said that creating geographical districts would equalize opportunities among all MSMS members to become elected to the AMA delegation.

After considerable discussion, the chair suggested a compromise by creating a slotted seat for a delegate and alternate delegate in the geographic area encompassing the northern Lower Peninsula and all of the Upper Peninsula. A lengthy discussion of the pros and cons of such a slotted seat followed a motion to accept the compromise. Approaching 5 p.m., Task Force members agreed to table the discussion until a subsequent meeting. In the meantime, staff was instructed to develop several maps including one to indicate the counties from which existing AMA delegates and alternates are members, a map showing a slotted seat north of a line roughly from Muskegon to Saginaw to Port Huron, and various scenarios for geographic districts based as closely as possible to equal division of existing MSMS membership. Task Force member Allan C.D. Brown, MD, also developed a map using combinations of existing District Director districts and noted that under this plan delegates and alternates would be nominated at the local geographic district level and voted upon by the full House of Delegates. These maps were mailed to Task Force members for study prior to the January 31 meeting.

At the January 31 meeting, the chair asked Task Force members to vote whether or not each felt there was a need to change the way AMA delegates and alternates are elected. Eight members voted for no change and four voted yes. He then asked those who were in favor of change to specify how they would make the change. One option was the slotted seat for the northern portion of the state. The second option was the geographical districts based on combinations of existing Board of Directors seats.

#### SLOTTED SEAT FOR NORTHERN MICHIGAN AMA DELEGATE

The minority favoring a slotted seat for northern Michigan pointed out that it would be a compromise position as a place to begin a change and see how it progresses over the years. Candidates from that area would still be required to be nominated from that slotted district and voted in by the full House of Delegates. They pointed out that it would give a member from that area a degree of hope when mounting a campaign and that the effort would not be prone to futility based simply on numbers.

#### GEOGRAPHIC AMA SEATS BASED ON DISTRICT DIRECTOR DISTRICTS

The minority favoring geographic seats argued that many potential candidates do not have the ability to become known within MSMS, but could become viable candidates within a smaller district more easily. They also argued that the current statewide voting gives candidates from the larger counties an unfair advantage because county delegations tend to vote in a block for their local candidates. They contend that existing District Director districts could be combined, as necessary, to create six fairly equal districts based on the membership/delegate count in each. They agreed that full implementation would take many years if a geographic district system is implemented as AMA delegation seats become vacant, but, that in the long run, such a system will be more equitable.

## NO CHANGE IN VOTING FOR AMA DELEGATES

The majority voting for no change argued that the existing open voting allows any MSMS member to become involved in organized medicine and then working his or her way up the ranks of leadership roles in a variety of ways including through the several MSMS sections, through county society offices, through MSMS committees, through the MSMS House of Delegates and then campaigning effectively for election. They argued that slotting a seat could create a precedent for other slots, for example, by specialty or gender. They argued that issues at the AMA level affect all Michigan physicians, regardless of their location within the state, and that the Michigan Delegation to the AMA is considered one of the most effective delegations within the AMA. They also pointed out that implementing a system of voting by districts would take decades to fully implement as seats became open unless the entire existing Michigan Delegation was summarily removed from office, which also would affect three current delegates now serving on AMA councils or other AMA leadership roles.

The Board agreed with the recommendation of the Task Force that every effort be made to foster all members, and particularly to mentor younger members, in becoming involved in leadership roles within organized medicine.

The MSMS Board of Directors approved the recommendation of the Task Force and recommends that the 2007 House of Delegates adopt Board Action Report #2 on Resolution 9-05A, which recommended that the House of Delegates take no action on the original resolution.

*RATIONALE: The Committee agreed with testimony that an open process already exists for AMA delegation elections. At the same time, the Committee recognized the challenges of out-state leadership development and candidacy. The Committee also recognized that there are existing avenues for leadership development through MSMS, and recommended that these be fortified to especially focus on out-state areas in order to assist in the identification and nurturing of potential future leaders in the AMA.*

## **BOARD ACTION REPORT #17 – Revisions to the MSMS Policy Manual.**

**The House approved the Board's recommendation that the edits to the MSMS Policy Manual be APPROVED AS AMENDED.**

RECOMMENDATION: That the attached edits to the MSMS Policy Manual be approved.

The Committee met on January 10 to review actions of the MSMS Board of Directors for the period of October 2005 to July 2006 and the actions of the 2006 House of Delegates for potential inclusion into the MSMS Policy Manual.

Once approval has been received from the House of Delegates, the updated version of the Policy Manual will be made available on the MSMS website.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates approve the edits to the MSMS Policy Manual.

## MSMS Policy Manual Addendum to 2005 Edition

### **ASSISTED SUICIDE, DEATH AND DYING, PAIN MANAGEMENT**

#### Pain Management Education and CME Credit

MSMS supports the concept of requiring physicians to be educated in pain management techniques but opposes mandating this type of education through CME credit. (Board-Mar94)

-Reaffirmed (Board-Oct05)

### **BIOETHICS**

#### Stem Cells and Cloning

MSMS supports federal and state policies that permit use of embryonic stem cells and somatic cell nuclear transfer in basic and clinical research including funding for such research based on its scientific merit. (Res60-HOD03A)

-Reaffirmed (Res70-HOD06A)

MSMS supports laws and governmental policies that prohibit human reproductive cloning. (Res60-HOD03A)

-Reaffirmed (Res70-HOD06A)

### **BIRTH CONTROL** (see FAMILY PLANNING AND SEX EDUCATION)

#### Over the Counter Contraception (The Morning After Pill)

MSMS supports the concept of making the “morning after” contraceptive pill an over the counter medication. (Res6-HOD06A)

### **ELECTRONIC MEDICINE**

#### e-Visit Reimbursements

MSMS supports and advocates reimbursement of e-visits that involve encounters relating to a patient’s care as a part of ongoing management and maintains appropriate elements of quality, physician accountability, and confidentiality. (Board-April06)

### **ENVIRONMENT**

### Policy Statement of Environmental Pollution

MSMS supports efforts to improve environmental health. MSMS supports all agencies charged with the control of environmental pollution. (Prior to 1990)

-Edited 1998

-Reaffirmed (Res35-HOD05A)

## **HEALTH CARE DELIVERY**

### Universal Health Care Access

~~MSMS supports the principle of universal access to health care. (Res59-HOD04A)~~

### Universal Coverage

MSMS supports comprehensive health system reform described in the MSMS Future of Medicine Report. (Res81-HOD06A)

*See also:*

*Addendum P "Guiding Principles for the Future of Medicine and Health Care"*

### Job Security for Returning Soldiers

MSMS supports efforts that provide job protection to medical professionals who are military reservists while they are away on a tour of duty. (Res48-HOD06A)

## **HOSPITAL BOARDS**

### Physician Representation on Hospital Boards of Trustees

MSMS supports the principle that all physicians seated on hospital boards of trustees be elected to their position by the hospital medical staff members. (Res51-HOD06A)

## **PUBLIC HEALTH**

### Junk Food in Schools

MSMS supports working toward the total elimination of selling junk food as defined by the USDA in elementary, middle, and high schools in the state of Michigan.

(Res44-HOD06A)

## **TOBACCO**

### Ban on Smoking in Public Places

MSMS supports seeking legislation at the state level calling for a ban on smoking in all public places. (Res93-HOD06A)

*RATIONALE: The Committee accepted a friendly amendment to the policy originally titled, "Junk Food Tax," and revised it to read, "Junk Food in Schools," which is more reflective of the intent of the policy.*

Guiding principles for the future of medicine and health care

| <b>1. Promote a culture of wellness and healthy communities.</b>   | <b>Actions</b>   |
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| <p>a. Provide leadership and coordination among all stakeholders on community-wide approaches to improve health in the broadest sense (education, environment, poverty, and other determinants of health) and reduce risk factors for disease.</p> | <ul style="list-style-type: none"> <li>▪ Invite key stakeholder organizations to exchange information about their wellness activities.</li> <li>▪ Encourage stakeholder organizations to coordinate efforts and leverage resources by developing a common agenda pertaining to the foundations of community wellness (physical and behavioral health), including prevention, monitoring, treatment and education.</li> <li>▪ Generate support for state anti-tobacco/anti-smoking legislation.</li> </ul>  |
| <p>b. Revitalize the public health system in communities and the state by emphasizing community-wide public health measures that complement the work of the medical care system.</p>   | <ul style="list-style-type: none"> <li>▪ Advocate for legislation that rebuilds and strengthens Michigan’s state and local public health system and encourages collaboration across medical and public health communities.</li> <li>▪ Seek ways to strengthen the Michigan Board of Health to help prioritize public health initiatives and maximize limited state resources.</li> </ul>   |
| <p>c. Strengthen efforts to address health risk behaviors that can impact the frequency or severity of chronic diseases in Michigan.</p>   | <ul style="list-style-type: none"> <li>▪ Develop models for improving nutrition education in schools.</li> <li>▪ Convene stakeholders in wellness to consolidate and strengthen disparate efforts to reduce behavioral risk factors. Research on the health care, productivity, and absenteeism costs associated with risk factors can be the foundation for broad-based wellness efforts in Michigan.</li> <li>▪ Support appropriate legislative and regulatory efforts to allow insurers and employers to provide positive incentives to patients for healthy behaviors and prevention efforts.</li> </ul> |
| <b>2. Raise expectations for safe, high-quality, accessible health care for all patients.</b>  | <b>Actions</b>   |

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| <p>a. Strive for high functioning, continuously improving systems of care that link providers with each other and their patients through seamless clinical integration and the information that supports it.</p>   | <ul style="list-style-type: none"> <li>▪ Support the implementation of the recommendations of the State Commission on Patient Safety.</li> <li>▪ Encourage physicians and health care organizations to focus on assessing and strengthening system capability that fosters (a) effective identification of patients with ongoing needs and communication about those needs and (b) effective coordination of care across treatment settings (i.e., identifying chronic disease patients, proactively reaching out to them to facilitate the best care, and tracking them over time).</li> <li>▪ Identify sources of expertise in health care systemization for physician offices and health care organizations in which physicians practice.</li> <li>▪ Identify 8-10 features of the ideal medical office and assist physicians in building them into their practices.</li> <li>▪ Work regional health information organizations on the development of regional and statewide health information networks.</li> <li>▪ Work with the newly established health information technology task force in the Michigan House of Representatives.</li> <li>▪ Promote e-health information tools, such as e-rx, e-lab, e-visit, and e-personal health record tools as an interim step for compiling patient medical information until electronic medical records are more widely implemented.</li> <li>▪ Support individual physicians in self-assessment or self-improvement in their practices and in making the inevitable transition to electronic offices as efficiently as possible.</li> </ul> |
| <p>b. Recognize that high quality care means access to the full range of essential services that can benefit patients: primary and secondary prevention, screening and diagnosis, acute care, coordinated management of chronic illness, long-term care, and mental health services.</p> | <ul style="list-style-type: none"> <li>▪ Ask the appropriate MSMS group (committee or task force) to develop a position statement on minimum essential benefits that will jumpstart a discussion with other stakeholders.</li> <li>▪ Convene a discussion with stakeholder organizations to discuss minimum essential benefits and to identify gaps in access to them as a starting point for public policy discussions about how to close those gaps.</li> <li>▪</li> <li>▪ Advocate for mental health coverage</li> </ul>  |

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|   | <p>parity.</p> <ul style="list-style-type: none"> <li>▪ Advocate for coverage of childhood immunizations by all health plans.</li> </ul>  |
| <p>c. Enable the rapid and universal adoption of tools and practices to ensure high quality medical care.</p> | <ul style="list-style-type: none"> <li>▪ Work with physicians and other providers, payers, employers and government policy makers to define and advocate for best practices in medical care, including evidence-based medicine and quality protocols.</li> <li>▪ Work with payers to make available to physicians and other providers information they can act upon to improve quality of care.</li> </ul>  |
| <p>d. Reform payment systems to support quality practice.</p>   | <ul style="list-style-type: none"> <li>▪ Work with physicians and other providers, payers, employers and government policy makers to define and advocate for reimbursement policies that encourage best practices in medical care, including evidence-based medicine and quality protocols.</li> <li>▪ Seek uniformity of measures and guidelines among health plans, including consistent screening guidelines.</li> <li>▪ Develop a proactive position on incentive programs consistent with the Michigan State Medical Society Principles on Pay-for-Performance Programs and explore ways to partner with payers in developing and implementing innovative approaches to using incentives to assess and improve the quality of care (encourage payers to reward for implementing electronic information systems; reward for improving systems for chronic illness management; advocate for revamping reimbursement systems to pay for essential primary and secondary prevention services, patient education, and shared decision-making activities, in the context of coordinated care management by physicians practicing in organized systems of care).</li> </ul><br><ul style="list-style-type: none"> <li>▪ Convene Michigan leaders in pay-for-performance programs—MSMS,</li> </ul> |

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|   | <p>Greater Detroit Area Health Council's Save Lives Save Dollars, individual health plan programs, the Michigan Hospital Association, employers, Medicare and Medicaid, and others—to develop guidelines for a statewide design that moves toward standardization of such programs to foster quality, promote fairness, and relieve providers from the unnecessary variation in pay-for-performance programs.</p>  |
| <p>e. Provide care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, insurance coverage, and socioeconomic status.</p>  | <ul style="list-style-type: none"> <li>▪ Educate physicians and other providers about common guidelines and measurements, such as those developed by the Michigan Quality Improvement Consortium (MQIC), and encourage broader adoption of those guidelines by payers.</li> <li>▪ Encourage consistent use of such guidelines with all patients.</li> </ul>  |
| <p>f. Reduce waits and potentially harmful delays in access to care for patients and access to information about patients for physicians and other providers.</p>   | <ul style="list-style-type: none"> <li>▪ Work with specialty societies to encourage physician participation with Medicaid in underserved areas.</li> </ul>   |
| <p>g. Restructure the current liability system to promote effective physician oversight and accountability, reduce waste from defensive medicine, and afford timely assistance to those harmed in the health care system.</p> | <ul style="list-style-type: none"> <li>▪ Explore other options to the current medical litigation system (e.g., no fault, health courts, etc.)</li> <li>▪ Support error reporting systems that will allow open transfer of information on system and technical malfunctions in order to improve patient safety.</li> <li>▪ Educate physicians and physician organizations about protections offered through the creation of a Patient Safety Organization (PSO).</li> </ul> |

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| <p>h. Engage patients in medical decision-making and support a stronger physician/patient partnership in making treatment choices.</p>  | <ul style="list-style-type: none"> <li>▪ Identify methods that support physician/patient partnership in the delivery of best care for disease categories and support distribution of those tools to physicians (e.g., standardized messages to patients, wallet cards for patients, quick view sheets for medical records).</li> <li>▪ Hold discussions with other stakeholder groups about best ways to educate patients about optimum physician-patient partnerships and provide relevant and understandable information to the patient.</li> </ul>            |
| <p>i. Provide care that is respectful of and responsive to individual patient preferences, needs, and values.</p>   | <ul style="list-style-type: none"> <li>▪ Explore ways to further distribute information to physicians about patient health literacy and cultural diversity training. Encourage customer service practices that are responsive to patient preferences, needs and values.</li> </ul>   |
| <p><b>3. Optimize value through a reformed health care delivery market.</b></p>   | <p><b>Actions</b></p>  |
| <p>a. Seek the commitment of physicians, other providers, payers, purchasers, and patients to the efficient and effective use of resources that assures affordability and access.</p> | <ul style="list-style-type: none"> <li>▪ Provide leadership in convening stakeholders in a discussion about the principles outlined in MSMS board position regarding universal health care access report.</li> <li>▪ Create incentives to fund the public health system to optimal levels for clinical care activities, including pre- and post-natal care, school health nurses, and immunizations.</li> </ul>  |
| <p>b. Establish a fundamentally different economic model for medical care services.</p>   | <ul style="list-style-type: none"> <li>▪ Advocate for a reduction in the number of insurance product designs and other methods to substantially reduce the administrative costs for employers, patients, payers and physicians.</li> <li>▪ Convene innovators in health plan design and health care delivery and finance to develop new generation plan designs that pay providers fairly for cognitive services, preventive care, chronic disease management, and other services that are now undervalued in current plan designs and reimbursement.</li> </ul> |

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| <p>c. Assure an adequate supply of physicians and other health professionals—both in number and in mix—to care for all residents.</p>                   | <ul style="list-style-type: none"> <li>▪ Secure adequate funding for medical schools and graduate medical education to ensure the appropriate supply of physicians to serve all residents.</li> <li>▪ Address revenue needed to appropriately fund nurse and allied health professionals training.</li> <li>▪ Work with the newly established MDCH Bureau of Health Professions' Center for Health Professions to gather information and develop strategies to address the undersupply of physicians and other health professions.</li> <li>▪ Explore funding sources to expand primary care access in underserved areas, including the option of developing a primary care capital corporation.</li> </ul> |
| <p><b>4. Deliver universal coverage through a reformed insurance market.</b></p>  | <p><b>Actions</b></p>   |
| <p>a. Ensure universal coverage for essential physical and behavioral health benefits and address ways to share responsibility for cost and access.</p> | <ul style="list-style-type: none"> <li>▪ Bring stakeholders together to forge common principles and a starting point for a community strategy aimed at universal access to care.</li> <li>▪ Support statewide coalitions to enhance efforts for the uninsured.</li> </ul>   |
| <p>b. Help make coverage options available for all residents.</p>   | <ul style="list-style-type: none"> <li>▪ Partner with county medical societies and other local entities to engage with state and local public health authorities to encourage efforts to establish and sustain basic benefit health plans, using public funds (federal, state and county), for indigent residents who are otherwise unable to obtain health insurance.</li> <li>▪ Investigate the formation of large group insurance pools as a strategy to broaden coverage to the uninsured.</li> </ul>   |

**BOARD ACTION REPORT #18 – HOD Late Resolution 96-06A – Increase Value of Membership.**

**The House approved the Board's recommendation that this resolution be DISAPPROVED.**

RECOMMENDATION: That the 2007 House of Delegates disapprove Resolution 96-06A, "Increase Value of Membership."

Late Resolution 96-06A was referred to the MSMS Board of Directors for study. The Board assigned the resolution to the Committee on Membership Recruitment and Retention for review and recommendation.

Resolution 96-06A asked the MSMS Board of Directors to examine the feasibility of approving Michigan county societies' meeting lectures for CME credit without charge to the county society where such meetings meet the existing criteria for CME approval.

The Committee considered this resolution at its meeting on December 12, 2006.

County medical societies are charged \$150 per CME application, compared to other accrediting bodies that charge an average of \$1,000. Counties have the ability to cut that cost by applying for multiple programs at one time for one application fee of \$150. All MSMS internal CME meetings also pay a \$150 application fee. Additionally, the MSMS Education Department fills out the application as an additional benefit to the county society.

MSMS collects approximately \$7,500 in application fees annually. This revenue is used to pay ACCME CME accreditation fees.

The Committee asked that MSMS provide the county societies with a written explanation of the application process and the above points so they have a better understanding of this practice. They concurred that this fee is extremely reasonable and critical to the MSMS CME budget.

The MSMS Board of Directors approved the recommendation of the Committee and recommends that the 2007 House of Delegates disapprove this resolution.

### **BOARD ACTION REPORT #19 – HOD Resolution 86-06A – Realignment of County Medical Societies.**

**The House approved the Board's recommendation that NO ACTION be taken on this resolution.**

RECOMMENDATION: That the 2007 MSMS House of Delegates take no action on Resolution 86-06A, "Realignment of County Medical Societies."

Resolution 86-06A, "Realignment of County Medical Societies" was referred by the 2006 House of Delegates to the MSMS Board for further study. The Board appointed the Task Force on Federation issues to review the present number of county medical societies, and where applicable, recommend changes in county medical society alignment.

The Task Force on Federation issues met on November 8, 2006, and discussed the resolution in-depth. Resolution author Joseph J. Weiss, MD, from Wayne County, joined the Task Force by way of telephone teleconference to argue that the Task Force should recommend that the MSMS Board of Directors review the status and functioning of county societies periodically to possibly merge or combine counties if favorable conditions exist to do so.

Doctor Muenk pointed out that reports from previous task forces looking at regionalization in Southeast Michigan and West Michigan already recommend that the MSMS Board continually review ways to streamline county societies, including merging, if feasible. Several members of the Task Force also expressed concerns about the MSMS Board getting too involved in the operation of county societies.

After considerable discussion, the Task Force recommended that the MSMS Board recommend to the House of Delegates that the Board continue to review recommendations of past regionalization task forces and recommend that the House of Delegates take no action on this resolution.

The MSMS Board of Directors approved the Task Force's recommendation and recommends that the 2007 House of Delegates take no action on this resolution.

*RATIONALE: The Committee heard testimony that it is not within the purview of MSMS to force realignment of county medical societies. The Committee was reminded that MSMS is open to assisting counties that choose to realign, reorganize, or develop other operational efficiencies.*